California Medical Association
Physicians dedicated to the health of Californians

November 7, 2011

Azadeh Mohandessi-Fares
CalOHII
1600 9th Street, Room 460
MS 20-10
Sacramento, CA 95814

RE: **Comments of the California Medical Association Relative to Proposed Health Information Exchange (HIE) Demonstration Projects**

Dear Ms. Mohandessi-Fares:

On behalf of the California Medical Association (CMA), thank you for the opportunity to comment on the proposed regulations establishing HIE demonstration projects pursuant to Assembly Bill (AB) 278.

CMA would like to express our appreciation to CalOHII for the many changes that have beenmade since the previous version of this proposed regulation. It is apparent from the new version that CalOHII spent a great deal of time thoughtfully considering the comments of CMA and others on the previous regulation.

Specifically, CMA believes that this new proposed regulation offers substantially more flexibility for HIEs in the management of patient consent. For example, allowing for central consent management will remove a considerable burden from small practice physicians, and will greatly improve participation in the proposed projects.

CMA also appreciates that the proposed regulations include significant coordination with existing rules for release of personal health information (PHI) with HIPAA and the Confidentiality of Medical Information Act (CMIA). Since these are, respectively, the federal and state laws governing the use of PHI, aligning the demonstration projects with them will reduce physician confusion.

That being said, there are still several areas in which CMA believes the proposed regulations could be improved. They are described in detail below.

1. **§126020(v) – Remove "health care provider" from the definition of "Participant"**
   "Participant" is meant to indicate the legal entity operating the demonstration project, which is most likely to be an existing health information organization (HIO) or an entity that operates a proprietary HIE, such as an independent practice association (IPA). It will not be

a small practice physician or other health care provider. By definition, a single health care provider cannot operate an exchange.

Including "health care provider" in this definition causes confusion in subsequent sections of the regulation (see the next comment) about whether the section is intended to reference the HIO or the individual provider participating therein.

2. **§126040(b)(2) – Clarify that Participant Only Needs to Collect Relevant Portions of a Provider's EHR Contract**
   There are two ways that this proposed subsection could cause confusion.

   First, an entity operating a demonstration project, such as an HIO, is highly unlikely to hold an EHR vendor contract. That contract would be held at the individual provider level. As currently drafted, however, the definition of "Participant" potentially includes both the HIO and the individual provider. Either the definitions should be separated, as described above, or the wording of this subsection needs to be clarified to indicate that it is the individual providers' EHR contracts which should be collected and stored.

   Second, requiring HIOs to hold the complete EHR vendor contract of each participating physician would be extremely burdensome to those entities. EHR vendor contracts for even small medical groups can run hundreds if not thousands of pages. Most of those pages would be technical specifications and legal disclosures with no bearing on the HIO, exchange of data, or the demonstration projects. Therefore, the regulation should be amended to allow the HIO to only collect the portions of the EHR vendor contract relevant to the operation of the demonstration projects.

3. **§126030(a)(3)(c) – Clarify that physicians have the right and the responsibility to maintain the integrity of the medical record.**
   CMA commented on this subsection in the previous version of the regulation, and is disappointed that it has not been altered in the current version.

   It is vitally important for patients to work with their physicians to maintain the accuracy of the data in the medical record. Therefore, CMA generally supports the right of patients to challenge their records if they are not accurate. That being said, physicians are held legally and ethically responsible for the integrity of the medical record, and they must have the discretion to update it as clinically appropriate.

   CMA requests again that CalOHII strike the language of this subsection and replace with: "Comment on the accuracy and/or completeness of the medical record, and request corrections."

4. **§126060(b)(3)(B)(iv) – Delete this subsection, as it is vague and unnecessary.**
   It appears that the intent of this subsection is to create higher standards for the handling of very sensitive information, such as HIV status or evidence of substance abuse. While CMA understands this intent, this subsection is both vague and unnecessary.

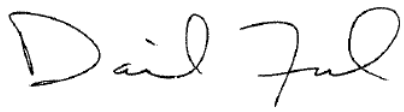
As written, this subsection leaves open-ended what information would be considered "particularly sensitive." For example, recording that a female patient is pregnant could be sensitive or not, depending on the circumstances of the pregnancy. Without a firm definition, this subsection could open physicians to lawsuits.

This subsection would also appear to create a higher standard, above either HIPAA or CMIA, but only for this unspecified subset of patient information. This could cause both physicians and HIOs to operate under two sets of rules for the same patient.

CMA requests that CalOHII delete this subsection and allow the existing HIPAA and CMIA rules to govern all health information.

Thank you again for the opportunity to comment on this proposed regulation, and for your thoughtful consideration of CMA's previous comments. CMA looks forward to working with CalOHII to balance concern about patient privacy with the benefits of health information exchange.

Sincerely,



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